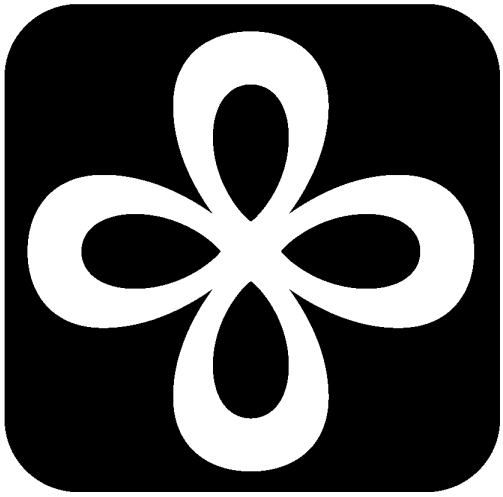
STATE OF IOWA
DEPARTMENT OF HUMAN SERVICES

MEDICAID



Provider Manual

Audiologist and Hearing Aid Dispenser

CHAPTER E: COVERAGE AND LIMITATIONS Page

CHAPTER F: BILLING AND PAYMENT Page

I. PROVIDERS ELIGIBLE TO PARTICIPATE

All hearing aid dispensers and audiologists licensed in Iowa or in another state are eligible to participate in the Medicaid Program. Submit requests for participation to the fiscal agent.

II. COVERAGE OF SERVICES

The following section explains limits on Medicaid coverage related to:

- Audiological testing
- Vestibular testing
- Prior authorization
- Binaural amplification
- Hearing aid dispenser services
- Replacement of hearing aids

A. Audiological Testing

Payment will be approved for audiologic testing performed to establish the recipient's need for a hearing aid. Covered testing services are:

- Hearing evaluation, which must include bone conduction and air conduction tests.
- Speech audiometry.
- Hearing aid selection.

The services of the audiologist also include at least one visit with the patient after the purchase of the hearing aid to determine whether the device is functioning adequately.

Payment will not be made for an evaluation for any other purpose, such as to evaluate the need for medical or surgical treatment. No payment is to be made to audiologists for services before the recipient's examination by a physician, except as noted under Item III. A, **Physician Examination**.

No payment is made for duplicate testing procedures.

Travel by the audiologist to perform the testing services may be approved when the recipient is unable to travel due to medical reasons. Travel will be approved only from the vendor's local base of operation to the recipient's home.

B. Vestibular Testing

Payment will be approved for vestibular function tests when prescribed by a physician to evaluate problems with vertigo and balance.

C. Prior Authorization

Prior authorization is required for the following:

- Replacement of a hearing aid less than four years old for recipients 21 years of age and older.
- A hearing aid costing more than $650.

D. Binaural Amplification

Binaural amplification is payable when:

- The aid is for a blind person, or
- The aid is needed for educational or vocational purposes, or
- Lack of binaural amplification poses a hazard to a recipient's safety, or
- The recipient's hearing loss has caused marked restriction of daily activities and constriction of interests, resulting in seriously impaired ability to relate to other people.

Medical records must document:

- The recipient's hearing condition.
- Copies of forms 470-0361, *Report of Examination for a Hearing Aid,* and 470-0828, *Hearing Aid Evaluation/Selection Report*.
- An outline of why binaural aids are necessary.
- Special need related to blindness, education, vocation rehabilitation, or speech development.

E. Hearing Aid Dispenser Services

For hearing aid dispensers, the following services are covered:

- Hearing aid selection, if the physician or audiologist gives a general hearing aid recommendation.
- Hearing aid, as recommended by an audiologist.
- Replacement of a hearing aid, under certain conditions. (See Item F, below.)
- Annual routine maintenance service on a hearing aid.
- Repair of hearing aids resulting from conditions not covered under the manufacturer's guarantee.
- Maintenance items, such as, batteries and cords, when obtained from an approved hearing aid dispenser or a retail pharmacy participating in the program.
- Vibrotactile aids, when the recipient has a diagnosis of bilateral profound sensory-neuro deafness with little or no benefit from a hearing aid.
- In-house repairs.

Consult with the audiologist if you feel that the hearing aid recommendation is not appropriate at the time the hearing aid is being fitted. If you cannot resolve the problem, refer it to the Bureau of Managed Care and Clinical Services for peer review committee consideration.

If a hearing aid is returned within the allowable period of return of the aid to the manufacturer, do so. Notify the Adjustment Section of the fiscal agent of the situation. Include copies of both claims and invoices, remittance statements, and any peer review documentation. An adjustment to your payment for the hearing aid will be made.

F. Replacement of Hearing Aids

Payment for the replacement of a hearing aid less than four years old requires prior authorization, except when the recipient is a child under 21 years of age. (See Chapter F for procedures.)

Payment for a replacement aid is approved when:

- The original hearing aid is lost or broken beyond repair, or
- There is a significant change in the person's hearing that requires a different hearing aid.

The prior authorization form should state the reason the hearing aid is being replaced and the length of time the recipient has had the aid.

Note: Adults requiring replacement of a hearing aid should have audiological tests reviewed by the physician or audiologist if the last evaluation is more than two years old. Children under 18 years of age should have an audiological test reviewed by the physician or audiologist before replacement of a hearing aid if the last evaluation is more than six months old.

Replacement of a hearing aid that no longer meets the needs of the recipient requires the same procedure as obtaining the original hearing aid, regardless of the length of time since the last evaluation.

III. PROCEDURE FOR A RECIPIENT TO OBTAIN A HEARING AID

The steps in the process for a Medicaid recipient to obtain a hearing aid are:

- Physician examination
- Audiological evaluation
- Hearing aid evaluation
- Hearing aid selection
- Hearing aid purchase

A. Physician Examination

Recipients who believe themselves to be in need of a hearing aid, or who are advised of a possible need, should begin by contacting their primary care physician. An examination by an otologist or otolaryngologist is preferred.

A physician must:

- Examine the recipient for any condition contraindicating the use of a hearing aid.
- Complete Section A of form 470-0361, *Report of Examination for a Hearing Aid*.

Exception: A physical examination may be waived if the recipient is 18 years of age or older and has signed an informed consent statement acknowledging that:

- The recipient has been advised that it may be in the recipient's best health interest to receive a medical evaluation from a licensed physician before purchasing a hearing aid, and
- The recipient does not wish to receive a medical evaluation before the purchase.

If the physician finds that the recipient has no condition that would contraindicate the use of a hearing aid, the physician gives a copy of the 470-0361 to the recipient to present to the recipient's audiologist of choice for the hearing test.

B. Audiologic Evaluation

A physician or an audiologist must perform pure-tone and speech audiometry to evaluate the recipient's hearing sensitivity. The audiologist or physician completes Sections B and C of form 470-0361, *Report of Examination for a Hearing Aid*. (This service corresponds to procedure code V5000.)

Due to various factors, such as age and cognitive ability to understand and respond, pure-tone air conduction, bone conduction, and speech audiometry may not be applicable to all recipients. If alternative audiological evaluations are employed, provide written documentation or attach supporting reports.

This evaluation may be completed by a physician or by an audiologist employed by the physician. If form 470-0361, Sections B and C, is not completed when returned from the physician, the recipient may be seen by an independently practicing audiologist of the recipient's choice.

C. Hearing Aid Evaluation

If a hearing aid evaluation is recommended on form 470-0361, Section C, an audiologist or physician must complete an evaluation on form 470-0361.

The hearing aid evaluation is performed to determine whether the recipient may benefit from the use of amplification. The evaluation procedures should be standard and appropriate as a means of determining the type of hearing aid and amplification characteristics needed for the recipient's condition.

D. Hearing Aid Selection

A physician or audiologist may recommend a specific brand or model appropriate to the recipient's condition. "Appropriate" shall mean adequate for the patient's condition and a reasonable expenditure as well.

The following considerations enter into the determination of reasonableness:

- Whether the expense of the item to the program would be clearly disproportionate to the therapeutic benefits which could ordinarily be derived from use of the item;
- Whether the item would be substantially more costly than a medically appropriate and realistically feasible alternative brand or model; or
- Whether the item serves essentially the same purpose as an item already available to the recipient.

When a physician or audiologist makes a general hearing aid recommendation, a hearing aid dispenser may perform tests to determine the specific brand or model appropriate to the recipient's condition. This shall be reported on form 470-0828, *Hearing Aid Evaluation/Selection Report*.

Prior authorization is required for all monaural hearing aids costing more than $650 and for all binaural hearing aids costing more than $1300. Payment will be approved for either of the following:

- Educational purposes when the recipient is participating in primary or secondary education or an academic program leading to a degree, and either:
  - An in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise, or
  - An in-office comparison of two aids, one of which is single-channel, shows significantly improved audibility; or
- Vocational purposes when documentation submitted indicates the necessity such as varying amounts of background noise in the work environment and a need to converse in order to do the job, and either:
  - An in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise, or
  - An in-office comparison of two aids, one of which is single-channel, shows significantly improved audibility.

E. Purchase of Hearing Aid

The recipient may purchase the hearing aid from the hearing aid dispenser of the recipient's choice who can provide the hearing aid recommended. Send the results of the audiologic evaluation and form 470-0828, *Hearing Aid Evaluation/Selection Report*, to the audiologist or dispenser of the recipient's choice.

IV. BASIS OF PAYMENT FOR SERVICES

A. Testing and Travel

The basis of payment for audiologic testing and hearing aid selection provided by a hearing and speech center or audiologist is a fee for service.

B. Hearing Aids

The basis of payment for hearing aid selection and hearing aids is fee-for-service or acquisition cost plus a dispensing fee. The dispensing fee includes all services related to the initial fitting and adjustment of the instrument and services for six months. Shipping and handling charges are not allowed.

When the submitted charge for a hearing aid is over $400, attach the invoice for the hearing aid to the claim. When the submitted charge is over $650, include the prior authorization number on the claim.

C. Maintenance Services

Maintenance service on hearing aids is payable one time per year after the initial six-month service period. Maintenance is payable only after the initial six-month service is rendered.

D. Replacement Ear Molds

Payment will be approved for replacement of hearing aid ear molds based on the current audiologist fee schedule.

Payment will be approved for a service charge in addition to the cost of material <u>if it is your practice to make such a service charge to the general public</u>.

When a service charge is made, it is considered to include all functions performed in connection with fitting of the ear mold, including travel, if necessary. Therefore, <u>no additional charge may be made</u> to the recipient or to others for service.

E. Repairs

1. Parts and Labor

Payment is made to the dispenser for repairs made by the dispenser. Payment for in-house repairs is made at the current fee schedule.

Payment is also made to the dispenser for repairs when the hearing aid is repaired by the manufacturer or manufacturer's depot. **Exception:** Do not bill Medicaid for services for repairs while the hearing aid is under warranty.

Payment for out-of-house repairs is made at the amount shown on the manufacturer's invoice. Payment is allowed for a service or handling charge when it is necessary for repairs to be performed by the manufacturer or manufacturer's depot and this charge is made to the general public.

2. Service Charge

Payment is approved for a service charge in addition to the charge for parts and labor if it is your practice to make such a charge to the general public. Bill the usual, customary, and reasonable service charge.

When a service charge is billed, it is considered to include all service functions performed in connection with repair of the hearing aid, including necessary travel, "loaners," or any other service or supplies. Therefore, no additional charge may be made to the recipient or to others.

F. Maintenance Items

The basis of payment for batteries is the current fee schedule. Other maintenance items, such as cords, are paid on the basis of the usual, customary, and reasonable charge, not to exceed what would be charged to the general public for such items.

Dispensing of hearing aid batteries is considered a service and must be documented in the patient's chart with the date of service and number of batteries dispensed. Up to 30 hearing aid batteries are covered within a 90-day period for a patient with a monaural hearing aid. Up to 60 hearing aid batteries are covered within a 90-day period for a patient with binaural hearing aids.

V. PROCEDURE CODES AND NOMENCLATURE

Iowa uses the HCFA Common Procedure Coding System (HCPCS).

A. Audiologists

Audiologists shall use the following codes and description of services in preparation of claims. Claims submitted without a procedure code and ICD-9-CM diagnosis code will be denied. (See Chapter F.)

Procedure Code	Service	Rate
69210	Removal of impacted cerumen	Fee for service
92541	Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording	Fee for service
92542	Positional nystagmus test, minimum of 4 positions, with recording	Fee for service
92543	Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests), with recording	Fee for service
92544	Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording	Fee for service
92545	Oscillating tracking test, with recording	Fee for service
92546	Sinusiodal vertical axis rotational testing	Fee for service
92547	Use of vertical electrodes (List separately in addition to code for primary procedure) (Use 92547 in conjunction with codes 92541-92546)	Fee for service
92551	Screening test, pure tone, air only	Fee for service
92552	Pure tone audiometry, air only	Fee for service
92553	Pure tone audiometry, air and bone	Fee for service
92555	Speech audiometry threshold	Fee for service

Procedure Code	Service	Rate
92556	Speech audiometry threshold, with speech recognition	Fee for service
92557	Comprehensive audiometry threshold evaluation and recognition (92553 and 92556 combined)	Fee for service
92563	Tone decay test	Fee for service
92565	Stenger test, pure tone	Fee for service
92567	Tympanometry	Fee for service
92568	Acoustic reflex testing	Fee for service
92569	Acoustic reflex decay testing	Fee for service
92577	Stenger test, speech	Fee for service
92579	Visual reinforcement audiometry	Fee for service
92582	Conditioning play audiometry	Fee for service
92583	Select picture audiometry	Fee for service
92585	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system	Fee for service
92587	Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products)	Fee for service
92588	Evoked otoacoustic emissions; comprehensive or diagnostic evaluation (comparison of transient or distortion product otoacoustic emissions at multiple levels and frequencies)	Fee for service
92589	Central auditory function tests (specify)	Fee for service
92590	Hearing aid evaluation and selection; monaural	Fee for service
92591	Hearing aid evaluation and selection; binaural	Fee for service
92592	Hearing aid check; monaural	Fee for service
92593	Hearing aid check; binaural	Fee for service
92594	Electroacoustic evaluation for hearing aid; monaural	Fee for service

Procedure Code	Service	Rate
92595	Electroacoustic evaluation for hearing aid; binaural	Fee for service
99082	Mileage, per mile, both ways	Paid at the same rate as state employees

B. Hearing Aid Dispensers

Hearing aid dispensers must use the following codes and description of services in preparation of claims. Claims submitted without a procedure code will be denied. (See Chapter F.)

1. Hearing Aids and Maintenance

Procedure Code	Service	Rate
W0121	Hearing aid selection (when audiologist or physician has not recommended a specific brand or model)	Fee for service
V5120	Hearing aid, binaural, body	Invoice if over maximum fee
V5130	Hearing aid, binaural	Invoice if over maximum fee, per aid
V5140	Hearing aid, binaural, behind the ear	Invoice if over maximum fee, per aid
V5150	Hearing aid, binaural, glasses	Invoice if over maximum fee
V5030	Hearing aid, monaural, body worn, air conduction	Invoice if over maximum fee
V5040	Hearing aid, monaural, body worn, bone conduction	Invoice if over maximum fee
V5050	Hearing aid, monaural, in the ear	Invoice if over maximum fee
V5060	Hearing aid, monaural, behind the ear	Invoice if over maximum fee

Procedure Code	Service	Rate
W0116	Vibrotactile aid and accessories	Invoice if over maximum fee
V5090	Dispensing fee for monaural aid provided for a person in other than nursing home	Bill 1 unit of service
V5160	Dispensing fee for binaural aid provided for a person in other than nursing home	Bill 1 unit of service
W0122	Dispensing fee for monaural aid provided for a person in a nursing home	Bill 1 unit of service
W0134	Dispensing fee for binaural aid provided for a person in a nursing home	Bill 1 unit of service
W0122	Dispensing fee for hearing aid (in recipient's home or nursing home when recipient is unable to travel)	Fee schedule
V5264	Ear mold with new hearing aid	Fee schedule
W0128	Annual service charge	Fee schedule

2. Hearing Aid Ear Molds

Procedure Code	Service	Rate
V5264	Ear mold replacement for existing hearing aids	Fee schedule
W0127	Service charge, ear mold	Fee schedule

3. Repairs

Procedure Code	Service	Rate
V5014	Repairs, material	Invoice
W0125	Service or handling charge (**Note:** Do not bill W0125 with W0131, in-house repairs.)	Usual customary and reasonable
W0131	In-house repair	Fee schedule

4. Maintenance Items

Procedure Code	Service	Rate
V5266	Hearing aid batteries, any type (each)	Fee schedule
V5267	Hearing aid supply/accessory	Usual, customary and reasonable

C. Modifier

For services performed as the result of an EPSDT (early and periodic screening, diagnosis, and treatment) examination, show modifier "Z1" after the five-digit procedure code.

VI. FACSIMILE MEDICAID FORMS

Supplies of forms 470-0828 and 470-0361 are available on request from the fiscal agent. These forms must be submitted with *Requests for Prior Authorization*, form 470-0829. They do not need to be submitted with the claim but must be maintained on file with the provider.

A. 470-0361, Report of Examination for a Hearing Aid

(See following pages for a sample of the form.)

B. 470-0828, Hearing Aid Evaluation/Selection Report

(See following pages for a sample of the form.)

Iowa Department of Human Services

REPORT OF EXAMINATION FOR A HEARING AID

All sections of this form must be completed. Section A indicates whether there are any reasons that would prohibit the use of a hearing aid. This section must be completed by an audiologist or a physician. **Section B** is required testing. This must be done by an audiologist who then indicates in Section C if a hearing aid evaluation may be appropriate for the recipient. **Section C** may be signed by the audiologist or by the physician.

SECTION A. INITIAL EVALUATION

Patient Name	Date of Birth	Medicaid Number MediPass ❑ Y ❑ N Spend Down ❑ Y ❑ N	
Address	City	State	Zip

Otoscopic Exam: Right ear ❑ Normal ❑ Excessive Cerumen Other (Explain) _____
Left ear ❑ Normal ❑ Excessive Cerumen Other (Explain) _____

Please check box if the condition is present:

- ❑ Visible congenital or traumatic deformity of the ear?
- ❑ History of /or active drainage from the ear within previous 90 days?
- ❑ Pressure or fullness feeling in the ear/s?
- ❑ Pain or discomfort in or around the ear/s, behind the ear/s?
- ❑ Sudden or rapid hearing loss within previous 90 days in one or both ears?
- ❑ Any history of noise exposure _____
- ❑ Acute or chronic dizziness, unsteadiness, lightheadedness?
- ❑ Ringing or noises in the ears/head? Describe _____
- ❑ Medical treatment or surgery of the ears OR cerumen removal? (Explain) _____
- ❑ Any known allergies? (Please list) _____
- ❑ Taking any medications? (Please list) _____
- ❑ Diabetic? Yes_____ No_____
- ❑ Familial history of hearing loss? (Explain) _____

Suspected cause of hearing loss: _____

Comments: _____

Recommendation for further care: _____ Audiologist for testing _____ Otologist/ENT

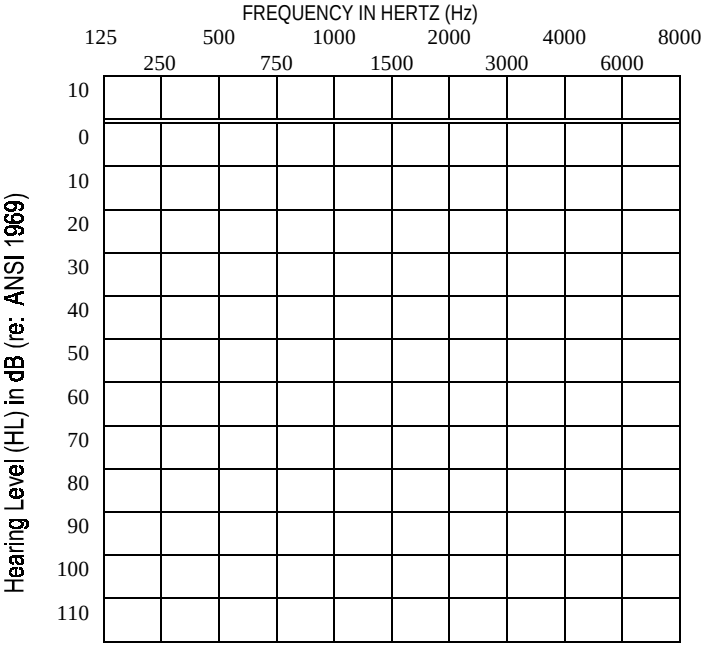
Signature of Physician/Audiologist	Date

Please print or type Physician's/Audiologist's name and address

The information requested on this form must be maintained within the patient's records.

SECTION B. AUDIOLOGIC EVALUATION

Name of Tester/Audiologist	Name of Practice
Street	City State Zip



SPEECH AUDIOMETRY (Re ANSI. 1969)

	SRT	MASK	Word Recognition Scores			MCL	UCL
			%	HL	MASK		
R							
L							
SF							
AIDED							

Audiometer:	LIVE ❑
Test Reliability:	Recorded ❑

LEGEND:	RIGHT	LEFT
AIR CONDUCTION	O	X
Masked Results	Δ	□
BONE CONDUCTION	<	>
Masked Results	[	]
NO RESPONSE	↓	↓

Tympanometry Results:
Normal/Type A ____
Type C ____
Type B ___

Remarks

If standard audiological procedures, are not appropriate for this patient please attach additional comments explaining what test procedures were used, along with the results.

SECTION C. RECOMMENDATIONS (To be completed by audiologist or physician after testing.)

❑ Hearing aid evaluation recommended	❑ Medical referral – ENT/Otologist
❑ No hearing aid evaluation recommended	❑ Medical Waiver Allowed
❑ Medical Clearance Received	❑ Other (explain)

Date	Signature of Audiologist/Physician

Iowa Department of Human Services

HEARING AID EVALUATION/SELECTION REPORT

To be completed by dispenser:

Name of Provider		Phone	
Address	City	State	Zip
Recipient Name	Date of Birth	Medicaid #	
Address	City	State	Zip

Hearing Aid Recommended: ❑ Right ❑ Left

Specifications of Appropriate Amplification

Linear	❑ Yes	❑ No	Compression	❑ Yes	❑ No
Programmable	❑ Yes	❑ No	Digital	❑ Yes	❑ No

Digital Justification (Use back of form for additional comments)

Type of Hearing Aid (check appropriate items)

❑ CIC ❑ Micro Canal ❑ Canal Aid / Half Shell
❑ Full Shell ITE ❑ Behind the ear ❑ Other _____
❑ CROS / BICROS Specify type and microphone & receiver placement:

Hearing Aid / Earmold Specifications

Manufacturer	Battery
Matrix	Options / Potentiometers
Earmold Type / Material	

Additional comments, information or impressions:

Date	Signature and Provider Type

I. REQUEST FOR PRIOR AUTHORIZATION FORM AND INSTRUCTIONS

A. How to Use

For services requiring prior approval (see Chapter E), form 470-0829, *Request for Prior Authorization*, must be completed and submitted to the fiscal agent. Do not use this form unless Medicaid requires prior approval for the service being provided.

The Medical Unit will review the request and make a determination of coverage. When a determination has been made, the form will be returned to you. If the service is approved for coverage, you may then submit your claim for reimbursement.

Important: Do not return the prior authorization form. Place the prior authorization number in the appropriate location on your claim form. (Consult the claim form instructions.) Using this number, the computer will then verify that the service has been approved for payment.

B. Facsimile of Request for Prior Authorization

(See page F – 3 for a facsimile of this form.)

C. Instructions for Completing Request for Prior Authorization

1. PATIENT NAME
   Complete the last name, first name and middle initial of the patient. Use the *Medical Assistance Eligibility Card* for verification.

2. PATIENT IDENTIFICATION NUMBER
   Copy this number directly from the *Medical Assistance Eligibility Card*. This number must be eight positions in length (seven numeric digits and one alphabetical character).

3. COUNTY NO.
   This is the number of the county where the recipient resides. It may be copied from the *Medical Assistance Eligibility Card*. This is a two-digit code. This area is optional.

4. DATE OF BIRTH
   Copy the patient's date of birth directly from the *Medical Assistance Eligibility Card*. Use two digits for each: month, day, year (MM, DD, YY).

5. PROVIDER PHONE NO.
   Completing this area may expedite the processing of your *Request for Prior Authorization*. This area is optional.

6. PROVIDER NO.
   Leave blank.

7. PAY TO PROVIDER NO.
   Enter the seven-digit provider number assigned to you by the Iowa Medicaid Program.

8. DATES COVERED BY THIS REQUEST
   Enter the appropriate date span. Be sure to include the date of service. Complete this item using two digits for each: month, day, year (MM, DD, YY). If this request is approved, it will be valid only for this period of time.

9. PROVIDER NAME
   Enter the name of the provider requesting prior authorization.

10. STREET ADDRESS
    Enter the street address of the provider requesting prior authorization.

11. CITY, STATE, ZIP
    Enter the city, state and zip of the provider requesting prior authorization.

12. PRIOR AUTHORIZATION NO.
    Leave blank.
    The fiscal agent will assign a number if the service is approved. You will then place this number in the appropriate area on the claim form.

REQUEST FOR PRIOR AUTHORIZATION

(PLEASE TYPE - ACCURACY IS IMPORTANT)

1. Patient Name (Last) (First) (Initial)			2. Patient Identification No.	3. Co. No.	4. Date of Birth Mo. Day Year
5. Provider Phone No.	6. Provider No.	7. Pay to Provider No.	8. Dates Covered by Request		
9. Provider Name			From: Mo. / Day / Year	To: Mo. / Day / Year	
10. Street Address			12. PRIOR AUTHORIZATION NO. (To be assigned by fiscal agent) Enter this number in the appropriate box when submitting the claim form for the services authorized.		
11. City, State, Zip					

13. Reasons For Request (use additional sheet if necessary)

SERVICES TO BE AUTHORIZED

14. Line No.	15. Describe Procedure, Supply, Drug To Be Provided or Diagnosis Description	16. Procedure, Supply, Drug or Diagnosis Code*	17. Units of Service	18. Leave Blank Authorized Units	19. Amount	20. Leave Blank Authorized Amount	21. Leave Blank Status
01							
02							
03							
04							
05							

IF THE PROVIDER OF THESE SERVICES WILL BE OTHER THAN THE PROVIDER NAMED IN BOX 9, PLEASE COMPLETE THIS PORTION.

22. Provider Name	23. Telephone No.	24. Provider No.	25. Pay to Provider No.
26. Street Address		City / State / Zip	

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the recipient continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the recipient's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the recipient continues to be eligible for Medicaid.

27. Requesting provider

_____ _____
Signature of Authorized Representative Date

FISCAL AGENT USE ONLY

28. MEDICAID BENEFITS ARE HEREBY ❑ APPROVED ❑ DENIED FOR THE RECIPIENT UNDER TITLE XIX, THIS AUTHORIZATION APPLIED ONLY TO THE ELIGIBLE PERSON ABOVE FOR THE SERVICE(S) SPECIFICALLY APPROVED ABOVE.

29. Comments or Reasons for Denial of Benefits

*PROCEDURE, SUPPLY, DRUG OR DIAGNOSIS CODES AUTHORIZED ON THIS REQUEST MUST BE THE SAME CODES ENTERED ON THE CLAIM FORM

30. Signature

_____ _____
Fiscal Agent's Authorized Representative Date

470-0829 (Rev. 4/98)

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13. REASON FOR REQUEST
Provide the required information in this area for the type of approval being requested. Refer to Chapter E of this manual. (For enteral products, enter the number of cans or packets administered per day.)

SERVICES TO BE AUTHORIZED

14. LINE NO.
No entry is required.

15. DESCRIBE PROCEDURE, SUPPLY, DRUG TO BE PROVIDED OR DIAGNOSIS DESCRIPTION
Enter the description of the service or services to be authorized. (For enteral products, enter the product name and NDC number.)

16. PROCEDURE, SUPPLY, DRUG OR DIAGNOSIS CODE
Enter the appropriate code. For prescription drugs, enter the appropriate NDC. For other services or supplies, enter the proper HCPCS code.

17. UNITS OF SERVICE
Complete with the amount or number of times the service is to be performed. (For enteral products, enter the number of cans or packets dispensed for the time span requested.)

18. AUTHORIZED UNITS
Leave blank. The fiscal agent will indicate the number of authorized units.

19. AMOUNT
Enter the amount that will be charged for this line item.

20. AUTHORIZED AMOUNT
Leave blank. The fiscal agent will indicate the authorized amount or indicate that payment will be based on the fee schedule or maximum fee depending on the service provided.

21. STATUS
Leave blank. The fiscal agent will indicate “A” for approved or “D” for denied.

22. PROVIDER NAME
Complete the name of the provider who will provide services, if other than requestor of prior authorization.

23. TELEPHONE NO.
Enter the telephone number of the provider who will provide services, if other than requestor of prior authorization. This area is optional.

24. PROVIDER NO.
Enter the seven-digit Medicaid provider number of the treating provider, if other than requestor of prior authorization.

25. PAY TO PROVIDER NO.
Enter the seven-digit group provider number for the treating provider, if other than requestor of prior authorization.

26. STREET ADDRESS, CITY, STATE, ZIP
Complete the street address, city, state and zip of the provider who will provide services, if other than requestor of prior authorization.

27. REQUESTING PROVIDER
Enter the signature of the provider or authorized representative requesting prior authorization. Also, indicate the date the request was signed.

FISCAL AGENT USE ONLY

28. MEDICAID BENEFITS REQUESTED ARE HEREBY
Do not complete. The fiscal agent will complete this item after evaluating the request.

29. COMMENTS OR REASON FOR DENIAL OF BENEFITS
Do not complete. The fiscal agent will complete this section should this request be denied.

30. SIGNATURE
Do not complete. The person making the final decision on this request will sign and date.

II. INSTRUCTIONS AND CLAIM FORM

A. Instructions for Completing the Claim Form

The table below contains information that will aid in the completion of the HCFA-1500 claim form. The table follows the form by field number and name, giving a brief description of the information to be entered, and whether providing information in that field is required, optional or conditional of the individual recipient's situation.

A star (*) in the instructions area of the table indicates a new item or change in policy for Iowa Medicaid providers.

For electronic media claim (EMC) submitters, refer also to your EMC specifications for claim completion instructions.

FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
1.	CHECK ONE	**OPTIONAL** – Check the applicable program block.
1a.	INSURED'S ID NUMBER	**REQUIRED** – Enter the recipient's Medicaid ID number found on the *Medical Assistance Eligibility Card*. It should consist of seven digits followed by a letter, i.e., 1234567A.
2.	PATIENT'S NAME	**REQUIRED** – Enter the last name, first name and middle initial of the recipient. Use the *Medical Assistance Eligibility Card* for verification.
3.	PATIENT'S BIRTHDATE	**OPTIONAL** – Enter the patient's birth month, day, year and sex. Completing this field may expedite processing of your claim.

4.	INSURED'S NAME	**CONDITIONAL*** – If the recipient is covered under someone else's insurance, enter the name of the person under which the insurance exists. This could be insurance covering the recipient as a result of a work or auto related accident. **Note:** This section of the form is separated by a border, so that information on this other insurance follows directly below, even though the numbering does not.
5.	PATIENT'S ADDRESS	**OPTIONAL** – Enter the address and phone number of the patient, if available.
6.	PATIENT RELATIONSHIP TO INSURED	**CONDITIONAL*** – If the recipient is covered under another person's insurance, mark the appropriate box to indicate relation.
7.	INSURED'S ADDRESS	**CONDITIONAL*** – Enter the address and phone number of the insured person indicated in field number 4.
8.	PATIENT STATUS	**OPTIONAL** – Check boxes corresponding to the patient's current marital and occupational status.
9a-d.	OTHER INSURED'S NAME	**CONDITIONAL*** – If the recipient carries other insurance, enter the name under which that insurance exists, as well as the policy or group number, the employer or school name under which coverage is offered and the name of the plan or program.
10.	IS PATIENT'S CONDITION RELATED TO	**CONDITIONAL*** – Check the appropriate box to indicate whether or not treatment billed on this claim is for a condition that is somehow work or accident related. If the patient's condition is related to employment or an accident, and other insurance has denied payment, complete 11d, marking the "YES" and "NO" boxes.
10d.	RESERVED FOR LOCAL USE	**OPTIONAL** – No entry required.

11a-c.	INSURED'S POLICY GROUP OR FECA NUMBER AND OTHER INFORMATION	**CONDITIONAL*** – This field continues with information related to field 4. If the recipient is covered under someone else's insurance, enter the policy number and other requested information as known.
11d.	IS THERE ANOTHER HEALTH BENEFIT PLAN?	**CONDITIONAL** – If payment has been received from another insurance, or the medical resource codes on the eligibility card indicate other insurance exists, check "YES" and enter payment amount in field 29. If you have received a denial of payment from another insurance, check both "YES" and "NO" to indicate that there is other insurance, but that the benefits were denied. **Note:** Auditing will be performed on a random basis to ensure correct billing.
12.	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	**OPTIONAL** – No entry required.
13.	INSURED OR AUTHORIZED PERSON'S SIGNATURE	**OPTIONAL** – No entry required.
14.	DATE OF CURRENT ILL-NESS, INJURY, PREGNANCY	**CONDITIONAL*** – Chiropractors must enter the date of the onset of treatment as month, day and year. All others – no entry required.
15.	IF THE PATIENT HAS HAD SAME OR SIMILAR ILLNESS…	**CONDITIONAL** – Chiropractors must enter the current x-ray date as month, day and year. All others – no entry required.
16.	DATES PATIENT UNABLE TO WORK…	**OPTIONAL** – No entry required.

17.	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	**CONDITIONAL** – Required if the referring physician does not have a Medicaid number.
17a.	ID NUMBER OF REFERRING PHYSICIAN	**CONDITIONAL*** – If the patient is a MediPASS recipient and the MediPASS physician authorized service, enter the seven-digit MediPASS authorization number. If this claim is for consultation, independent lab or DME, enter the Iowa Medicaid number of the referring or prescribing physician. If the patient is on lock-in and the lock-in physician authorized service, enter the seven-digit authorization number.
18.	HOSPITALI-ZATION DATES RELATED TO…	**OPTIONAL** – No entry required.
19.	RESERVED FOR LOCAL USE	**REQUIRED** – If the patient is pregnant, write "Y – Pregnant."
20.	OUTSIDE LAB	**OPTIONAL** – No entry required.
21.	DIAGNOSIS OR NATURE OF ILLNESS	**REQUIRED** – Indicate the applicable ICD-9-CM diagnosis codes in order of importance (1-primary; 2-secondary; 3-tertiary; and 4-quaternary) to a maximum of four diagnoses.
22.	MEDICAID RESUBMISSION CODE…	**OPTIONAL** – No entry required.
23.	PRIOR AUTHORIZATION NUMBER	**CONDITIONAL*** – Enter the prior authorization number issued by Consultec.

24. A	DATE(S) OF SERVICE	**REQUIRED** – Enter month, day and year under both the From and To categories for each procedure, service or supply. If the From-To dates span more than one calendar month, represent each month on a separate line. Because eligibility is approved on a month-by-month basis, spanning or overlapping billing months could cause the entire claim to be denied.
24. B	PLACE OF SERVICE	**REQUIRED** – Using the chart below, enter the number corresponding to the place service was provided. Do not use alphabetic characters. 11 Office 12 Home 21 Inpatient Hospital 22 Outpatient Hospital 23 Emergency Room – Hospital 24 Ambulatory Surgical Center 25 Birthing Center 26 Military Treatment Facility 31 Skilled Nursing 32 Nursing Facility 33 Custodial Care Facility 34 Hospice 41 Ambulance – land 42 Ambulance – air or water 51 Inpatient Psychiatric Facility 52 Psychiatric Facility – partial hospitalization 53 Community Mental Health Center 54 Intermediate Care Facility/Mentally Retarded 55 Residential Substance Abuse Treatment Facility 56 Psychiatric Residential Treatment Center 61 Comprehensive Inpatient Rehabilitation Facility 62 Comprehensive Outpatient Rehabilitation Facility 65 End-stage Renal Disease Treatment 71 State or Local Public Health Clinic 72 Rural Health Clinic 81 Independent Laboratory 99 Other Unlisted Facility

24. C	TYPE OF SERVICE	**OPTIONAL** – No entry required.
24. D	PROCEDURES, SERVICES OR SUPPLIES	**REQUIRED** – Enter the appropriate five-digit procedure code and any necessary modifier for each of the dates of service. DO NOT list services for which no fees were charged.
24. E	DIAGNOSIS CODE	**REQUIRED** – Indicate the corresponding diagnosis code from field 21 by entering the number of its position, i.e., 3. DO NOT write the actual diagnosis code in this field. Doing so will cause the claim to deny. There is a maximum of four diagnosis codes per claim.
24. F	$ CHARGES	**REQUIRED** – Enter the usual and customary charge for each line item.
24. G	DAYS OR UNITS	**REQUIRED** – Enter the number of times this procedure was performed or number of supply items dispensed. If the procedure code specifies the number of units, then enter "1." When billing general anesthesia, the units of service must reflect the total minutes of general anesthesia.
24. H	EPSDT/FAMILY PLANNING	**OPTIONAL*** – Enter an "F" if the services on this claim line are for family planning. Enter an "E" if the services on this claim line are the result of an EPSDT Care for Kids screening.
24. I	EMG	**OPTIONAL** – No entry required.
24. J	COB	**OPTIONAL** – No entry required.
24. K	RESERVED FOR LOCAL USE	**CONDITIONAL*** – Enter the treating provider's individual seven-digit Iowa Medicaid provider number when the provider number given in field 33 is that of a group and/or is not that of the treating provider.
25.	FEDERAL TAX ID NUMBER	**OPTIONAL** – No entry required.
26.	PATIENT'S ACCOUNT NUMBER	**OPTIONAL** – Enter the account number assigned to the patient by the provider of service. This field is limited to 10 alpha/numeric characters.

27.	ACCEPT ASSIGNMENT?	**OPTIONAL** – No entry required.
28.	TOTAL CLAIM CHARGE	**REQUIRED** – Enter the total of the line item charges. If more than one claim form is used to bill services performed, each claim form must be separately totaled. Do not carry over any charges to another claim form.
29.	AMOUNT PAID	**CONDITIONAL*** – Enter only the amount paid by other insurance. Recipient co-payments, Medicare payments or previous Medicaid payments are not listed on this claim.
30.	BALANCE DUE	**REQUIRED*** – Enter the amount of total charges less the amount entered in field 29.
31.	SIGNATURE OF PHYSICIAN OR SUPPLIER	**REQUIRED** – The signature of either the physician or authorized representative and the original filing date must be entered. If the signature is computer-generated block letters, the signature must be initialed. A signature stamp may be used.
32.	NAME AND ADDRESS OF FACILITY…	**CONDITIONAL** – If other than a home or office, enter the name and address of the facility where the service(s) were rendered.
33.	PHYSICIAN'S, SUPPLIER'S BILLING NAME…	**REQUIRED*** – Enter the complete name and address of the billing physician or service supplier.
	GRP #	**REQUIRED** – Enter the seven-digit Iowa Medicaid number of the billing provider. If this number identifies a group or an individual provider other than the provider of service, the treating provider's Iowa Medicaid number must be entered in field 24K for each line.
BACK OF FORM	NOTE	**REQUIRED** – The back of the claim form must be intact on every claim form submitted.

B. Facsimile of Claim Form, HCFA-1500 (front and back)

(See the following pages.)

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ 3. ____

2. ____ 4. ____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing date sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to HCFA, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008), Washington, D.C. 20503.

III. REMITTANCE ADVICE AND FIELD DESCRIPTIONS

A. Remittance Advice Explanation

To simplify your accounts receivable reconciliation and posting functions, you will receive a comprehensive *Remittance Advice* with each Medicaid payment. The *Remittance Advice* is also available on magnetic computer tape for automated account receivable posting.

The *Remittance Advice* is separated into categories indicating the status of those claims listed below. Categories of the *Remittance Advice* include paid, denied and suspended claims.

- PAID indicates all processed claims, credits and adjustments for which there is full or partial reimbursement.
- DENIED represents all processed claims for which no reimbursement is made.
- SUSPENDED reflects claims which are currently in process pending resolution of one or more issues (recipient eligibility determination, reduction of charges, third party benefit determination, etc.).

Suspended claims may or may not print, depending on which option was specified on the Medicaid Provider Application at the time of enrollment. You chose one of the following:

- Print suspended claims only once.
- Print all suspended claims until paid or denied.
- Do not print suspended claims.

Note: Claim credits or recoupments (reversed) appear as regular claims with the exception that the transaction control number contains a “1” in the twelfth position and reimbursement appears as a negative amount.

An adjustment to a previously paid claim produces two transactions on the *Remittance Advice*. The first appears as a credit to negate the claim; the second is the replacement or adjusted claim, containing a "2" in the twelfth position of the transaction control number.

If the total of the credit amounts exceeds that of reimbursement made, the resulting difference (amount of credit – the amount of reimbursement) is carried forward and no check is issued. Subsequent reimbursement will be applied to the credit balance, as well, until the credit balance is exhausted.

An example of the *Remittance Advice* and a detailed field-by-field description of each informational line follows. It is important to study these examples to gain a thorough understanding of each element as each *Remittance Advice* contains important information about claims and expected reimbursement.

Regardless of one's understanding of the *Remittance Advice*, it is sometimes necessary to contact the fiscal agent with questions. When doing so, keep the *Remittance Advice* handy and refer to the transaction control number of the particular claim. This will result in timely, accurate information about the claim in question.

B. Facsimile of Remittance Advice and Detailed Field Descriptions

(See the following pages.)

MEDICAID MANAGEMENT INFORMATION SYSTEM RUN DATE 06/12/97

REMITTANCE ADVICE

(1.) TO: [redacted] (2.) R.A. NO.: 0000006 (3.) DATE PAID: 05/19/97 (4.) PROVIDER NUMBER: [redacted] (5.) PAGE: 1

**** PATIENT NAME **** LAST	FIRST MI	RECIP ID / LINE	TRANS-CONTROL-NUMBER / SVC-DATE	PROC/MODS	UNITS	BILLED AMT.	OTHER SOURCES	PAID BY MCAID	COPAY AMT.	MED RCD NUM / PERF. PROV.	S	EOB	EOB
* (6.) CLAIM TYPE: HCFA 1500						* (7.) CLAIM STATUS: PAID							
ORIGINAL CLAIMS:			(10.)			(11.)	(12.)	(13.)	(14.)	(15.)		(16.)	
[redacted] (8.)	[redacted]	(9.) [redacted]	4-96331-00-053-0038-00			38.00	0.00	16.06	0.00	860600608B		900	000
		(17.) 01	(18.) 10/3 (19.)	99212	(20.) 1	(21.) 38.00	(22.) 0.00	(23.) 16.06	(24.) 0.00	(25.) [redacted]			000 000
[redacted]	[redacted]	[redacted]	4-96348-00-018-0060-00			50.00	0.00	35.26	0.00	860600608B			000 000
		01	11/15/96	J1055	1	41.00	0.00	33.18	0.00	[redacted]	(26.)	F	000 000
		02	11/15/96	90782	1	9.00	0.00	2.08	0.00	[redacted]		F	000 000

(27.)

REMITTANCE TOTALS					
PAID ORIGINAL CLAIMS:	NUMBER OF CLAIMS	2	---------	88.00	51.32
PAID ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	0	---------	0.00	0.00
DENIED ORIGINAL CLAIMS:	NUMBER OF CLAIMS	0	---------	0.00	0.00
DENIED ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	0	---------	0.00	0.00
PENDED CLAIMS (IN PROCESS):	NUMBER OF CLAIMS	0	---------	0.00	0.00
AMOUNT OF CHECK:					51.32

---- THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION OF BENEFIT (EOB) CODES THAT APPEAR ABOVE:

(28.) 900 THE CLAIM IS IN SUSPENSE. DO NOT RESUBMIT THE CLAIM.

Page 20 was intentionally left blank.

C. Remittance Advice Field Descriptions

1. Billing provider's name as specified on the Medicaid Provider Enrollment Application.

2. *Remittance Advice* number.

3. Date claim paid.

4. Billing provider's Medicaid (Title XIX) number.

5. *Remittance Advice* page number.

6. Type of claim used to bill Medicaid.

7. Status of following claims:

   - **Paid** – claims for which reimbursement is being made.
   - **Denied** – claims for which no reimbursement is being made.
   - **Suspended** – claims in process. These claims have not yet been paid or denied.

8. Recipient's last and first name.

9. Recipient's Medicaid (Title XIX) number.

10. Transaction control number assigned to each claim by the fiscal agent. Please use this number when making claim inquires.

11. Total charges submitted by provider.

12. Total amount applied to this claim from other resources, i.e., other insurance or spenddown.

13. Total amount of Medicaid reimbursement as allowed for this claim.

14. Total amount of recipient copayment deducted from this claim.

15. Medical record number as assigned by provider; 10 characters are printable.

16. Explanation of benefits code for informational purposes or to explain why a claim denied. Refer to the end of *Remittance Advice* for explanation of the EOB code.

17. Line item number.

18. The first date of service for the billed procedure.

19. The procedure code for the rendered service.

20. The number of units of rendered service.

21. Charge submitted by provider for line item.

22. Amount applied to this line item from other resources, i.e., other insurance, spenddown.

23. Amount of Medicaid reimbursement as allowed for this line item.

24. Amount of recipient copayment deducted for this line item.

25. Treating provider's Medicaid (Title XIX) number.

26. Allowed charge source code:

B Billed charge
F Fee schedule
M Manually priced
N Provider charge rate
P Group therapy
Q EPSDT total screen over 17 years
R EPSDT total under 18 years
S EPSDT partial over 17 years
T EPSDT partial under 18 years
U Gynecology fee
V Obstetrics fee
W Child fee

27. Remittance totals (found at the end of the *Remittance Advice*):

- Number of paid original claims, the amount billed by the provider and the amount allowed and reimbursed by Medicaid.
- Number of paid adjusted claims, amount billed by provider and amount allowed and reimbursed by Medicaid.
- Number of denied original claims and amount billed by provider.
- Number of denied adjusted claims and amount billed by provider.
- Number of pended claims (in process) and amount billed by provider.
- Amount of check.

28. Description of individual explanation of benefits codes. The EOB code leads, followed by important information and advice.

IV. PROBLEMS WITH SUBMITTED CLAIMS

To inquire as to why a claim was denied or why a claim payment was not what you expected, please complete form 470-3744, *Provider Inquiry*. Attach copies of the claim, the *Remittance Advice,* and any supporting documentation you want to have considered, such as additional medical records. Send these to:

Consultec, Attn: Provider Inquiry
PO Box 14422
Des Moines, Iowa 50306-3422

To make an adjustment to a claim following receipt of the *Remittance Advice,* use form 470-0040, *Credit/Adjustment Request*. Use the *Credit/Adjustment Request* to notify the fiscal agent to take an action against a paid claim, such as when:

- A paid claim amount needs to be changed, or
- Money needs to be credited back, or
- An entire *Remittance Advice* should be canceled.

Send this form to:

Consultec, Attn: Credits and Adjustments
PO Box 14422
Des Moines, Iowa 50306-3422

Do **not** use this form when a claim has been denied. Denied claims must be resubmitted.

A. Facsimile of Provider Inquiry, 470-3744

You can obtain this form by printing or copying the sample in the manual or contacting the fiscal agent. A facsimile of the form follows.

B. Facsimile of Credit/Adjustment Request, 470-0040

You can obtain this form by printing or copying the sample in the manual or contacting the fiscal agent. A facsimile of the form follows.

Iowa Medicaid Program

PROVIDER INQUIRY

Attach supporting documentation. Check applicable boxes: ❒ Claim copy ❒ Remittance copy
❒ Other pertinent information for possible claim reprocessing.

INQUIRY A

1. 17-DIGIT TCN

2. NATURE OF INQUIRY

(Please do not write below this line)
FOR CONSULTEC RESPONSE

INQUIRY B

1. 17–DIGIT TCN

2. NATURE OF INQUIRY

(Please do not write below this line)
FOR CONSULTEC RESPONSE

Provider Signature/Date:	**MAIL TO: CONSULTEC P. O. BOX 14422 DES MOINES IA 50306-3422**	**Consultec Signature/Date:**

Provider Please Complete:

7-digit Medicaid Provider ID#_____

Telephone_____

Name
Street
City, St
Zip

(FOR CONSULTEC USE ONLY)

PR Inquiry Log #_____

Received Date Stamp:

Page 26 was intentionally left blank.

Iowa Medicaid Program

CREDIT/ADJUSTMENT REQUEST

Do **not** use this form if your claim was denied. Resubmit denied claims.

SECTION A: Check the most appropriate action and complete steps for that request.

❑ CLAIM ADJUSTMENT	❑ CLAIM CREDIT	❑ CANCELLATION OF ENTIRE REMITTANCE ADVICE
♦ Attach a complete copy of claim. (If electronic, use next step.) ♦ Attach a copy of the Remittance Advice with corrections in **red ink**. ♦ Complete Sections B and C.	♦ Attach a copy of the Remittance Advice. ♦ Complete Sections B and C.	♦ Use only if all claims on Remittance Advice are incorrect. This option is rarely used. ♦ Attach the check and Remittance Advice. ♦ Skip Section B. Complete Section C.

SECTION B:

1. 17-digit TCN																	

2. Pay-to Provider #:	4. 8-character Iowa Medicaid Recipient ID: (e.g., 1234567A)

3. Provider Name and Address:

5. Reason for Adjustment or Credit Request:

SECTION C:	Provider/Representative Signature:
	Date:

CONSULTEC USE ONLY: REMARKS/STATUS

Return All Requests To:

Consultec
PO Box 14422
Des Moines, IA 50306-3422

October 22, 1996

For Human Services Use Only

General Letter No. 8-AP-5

Subject: Employees' Manual, Title 8, Medicaid Appendix

AUDIOLOGIST AND HEARING AID DEALER MANUAL TRANSMITTAL NO. 96-1

Subject: ***Audiologist and Hearing Aid Dealer Manual***, Table of Contents (pages 4 and 5), revised; Chapter E, *Coverage and Limitations*, pages 1 and 11 through 14, revised.

Summary

Procedure code W0126 (ear mold) has been revised to clarify that this service is for the replacement of existing hearing aids.

The *Report of Examination for a Hearing Aid*, Section B, Audiologic Evaluation has been revised to include the statement "Hearing Level (HL) in dB re: ANSI 1969," and a spelling correction.

Certain fees were adjusted. Providers should request a new fee schedule from Unisys Corporation.

Date Effective

October 1, 1996

Material Superseded

Remove from ***Audiologist and Hearing Aid Dealer***, Table of Contents, pages 4 and 5, and Chapter E, pages 1, 11, and 12, all dated October 1, 1993, and Chapter E, pages 13 and 14, *Report of Examiner Establishing the Need for a Hearing Aid*, MA-2113-0, dated 8/95, and destroy them.

Additional Information

If any portion of this material is not clear, please direct your inquiries to Unisys Corporation, fiscal agent for the Iowa Department of Human Services.

IOWA DEPARTMENT OF HUMAN SERVICES
Charles M. Palmer, Director

Donald W. Herman, Administrator
DIVISION OF MEDICAL SERVICES

March 27, 1997

For Human Services Use Only

General Letter No. 8-AP-22

Subject: Employees' Manual, Title 8, Medicaid Appendix

AUDIOLOGIST AND HEARING AID DEALER MANUAL TRANSMITTAL NO. 97-2

Subject: ***Audiologist and Hearing Aid Dealer Manual***, Table of Contents (page 4), revised; Chapter E, *Coverage and Limitations*, pages 1-4, 7, 8, and 11, revised.

Prior approval for binaural hearing aids will no longer be required for a child under 21 years of age.

Payment for certain maintenance items has been clarified. Payment for replacement ear molds will be at the current fee schedule.

Date Effective

April 1, 1997

Material Superseded

Remove the following pages from the ***Audiologist and Hearing Aid Dealer Manual***, and destroy them.

Page	Date
Table of Contents (page 4)	October 1, 1996
Chapter E:	
1	October 1, 1996
2, 3, 4, 7, 8	October 1, 1993
11	October 1, 1996

Additional Information

If any portion of this material is not clear, please direct your inquiries to Unisys Corporation, fiscal agent for the Iowa Department of Human Services.

IOWA DEPARTMENT OF HUMAN SERVICES
Charles M. Palmer, Director

Donald W. Herman, Administrator
DIVISION OF MEDICAL SERVICES

Iowa Department of Human Services

For Human Services use only:

General Letter No. 8-AP-58
Employees' Manual, Title 8
Medicaid Appendix

April 27, 1998

AUDIOLOGIST AND HEARING AID DEALER MANUAL TRANSMITTAL NO. 98-1

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***Audiologist and Hearing Aid Dealer Manual***, Table of Contents (page 5), revised; Chapter E, *Coverage and Limitations*, page 9, revised; and Chapter F, *Billing and Payment*, pages 1 through 23, revised.

This release adds the CPT codes for newborn hearing screening and updates billing and payment instructions.

Date Effective

June 1, 1998

Material Superseded

Remove the following pages from ***Audiologist and Hearing Aid Dealer Manual***, and destroy them:

Page	Date
Contents (page 5)	October 1, 1996
Chapter E	
9	October 1, 1993
Chapter F	
1	July 1, 1993
2	7/86
3-6	July 1, 1993
7, 8	12/90
9-17	July 1, 1993
18	Undated
19-21	06/18/93
22, 23	July 1, 1993

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.

Iowa Department of Human Services

For Human Services use only:

General Letter No. 8-AP-80
Employees' Manual, Title 8
Medicaid Appendix

August 17, 1998

AUDIOLOGIST AND HEARING AID DEALER MANUAL TRANSMITTAL NO. 98-2

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***Audiologist and Hearing Aid Dealer Manual***, Table of Contents (page 4), revised; and Chapter E, *Coverage and Limitations*, pages 8 through 10, revised.

This release adds the CPT codes 69210 and 92588 for audiologists and clarifies that the rate for V5130 is per aid.

Date Effective

August 1, 1998

Material Superseded

Remove the following pages from the ***Audiologist and Hearing Aid Dealer Manual*** and destroy them:

Page	Date
Contents (page 4)	April 1, 1997
Chapter E	
8	April 1, 1997
9	June 1, 1998
10	February 1, 1994

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.

Iowa Department of Human Services

For Human Services use only:

General Letter No. 8-AP-114
Employees' Manual, Title
Medicaid Appendix

May 21, 1999

AUDIOLOGIST AND HEARING AID DEALER MANUAL TRANSMITTAL NO. 99-1

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***Audiologist and Hearing Aid Dealer Manual***, Chapter E, *Coverage and Limitations*, pages 2, 7, 10, and 11, revised.

This release:

- Removes the prior authorization requirement for binaural hearing aids.
- Clarifies billing procedures for hearing aids.
- Clarifies that dispensing fees, ear molds, and batteries are paid on the basis of a fee schedule.

Date Effective

June 1, 1999

Material Superseded

Remove the following pages from ***Audiologist and Hearing Aid Dealer Manual*** and destroy them:

Page	Date
Chapter E	
2, 7	April 1, 1997
10	August 1, 1998
11	April 1, 1997

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.

Iowa Department of Human Services

For Human Services use only:

General Letter No. 8-AP-126
Employees' Manual, Title 8
Medicaid Appendix

October 29, 1999

AUDIOLOGIST AND HEARING AID DEALER MANUAL TRANSMITTAL NO. 99-2

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***Audiologist and Hearing Aid Dealer Manual***, Table of Contents (page 4), revised; Chapter E, *Coverage and Limitations*, pages 1 through 16, revised.

This revision:

- Permits waiver of medical evaluation by recipients age 18 and over before receipt of a hearing aid.
- Includes coverage for in-house repairs.
- Revises form numbers and form samples.

Date Effective

November 1, 1999

Material Superseded

Remove from the ***Audiologist and Hearing Aid Dealer Manual*** Contents (page 4) dated August 1, 1998, and the entire Chapter E and destroy them.

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.

Iowa Department of Human Services

For Human Services use only:

General Letter No. 8-AP-183
Employees' Manual, Title 8
Medicaid Appendix

April 25, 2002

AUDIOLOGIST AND HEARING AID DISPENSER MANUAL TRANSMITTAL NO. 02-1

ISSUED BY: Bureau of Managed Care and Clinical Services

SUBJECT: ***AUDIOLOGIST AND HEARING AID DISPENSER MANUAL***, Table of Contents (pages 4 and 5), revised; Chapter E, *Coverage and Limitations*, pages 1 through 16, revised; and page 17, new; Chapter F, *Billing and Payment*, pages 1, 2, 3, 5 through 14, 17, 18, 21, 22, and 23, revised; and pages 24 through 27, new.

Revisions to chapter E:

- Include the audiology CPT codes and identify HCPCS Level II codes replacing some local codes. Local codes will continue to be accepted until August 1, 2002.
- Establish prior authorization for hearing aids over $650.
- Add vestibular testing by audiologists when prescribed by a physician.
- Clarify that shipping and handling charges are considered a component of the dispensing fee and are not separately payable.

Revisions to chapter F:

- Update the sample prior authorization form to the current (1998) version.
- Add two forms to provide for an inquiry process for denied claims or if claim payment was not in the amount expected:
  - Complete form 470-3744, *Provider Inquiry*, if you wish to inquire about a denied claim or if claim payment was not as expected.
  - Complete form 470-0040, *Credit/Adjustment Request*, to notify Consultec that a paid claim amount needs to be changed, funds need to be credited back, or an entire *Remittance Advice* should be canceled.
- Update the term "hearing aid dealer" to "hearing aid dispenser" in the page headings.

Date Effective

March 1, 2002

Material Superseded

Remove the following pages from the ***Audiologist and Hearing Aid Dispenser Manual*** and destroy them:

Page	Date
Table of Contents (page 4)	November 1, 1999
Table of Contents (page 5)	June 1, 1998
Chapter E	
1-16	November 1, 1999
Chapter F	
1, 2	June 1, 1998
3	July 1997
5-14, 17, 18, 21-23	June 1, 1998

Additional Information

Only Chapter E pages are being mailed to providers. The updated provider manual containing the revised Chapter F pages can be found at:

www.dhs.state.ia.us/policyanalysis

If you do not have Internet access, you may request a paper copy of this manual transmittal by sending a written request to:

ACS/Consultec
Manual Transmittal Requests
PO Box 14422
Des Moines, IA 50306-3422

Include your Medicaid provider number, name, address, provider type, and the transmittal number that you are requesting.

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.

Iowa Department of Human Services

For Human Services use only:

General Letter No. 8-AP-189
Employees' Manual, Title 8
Medicaid Appendix

July 23 2002

AUDIOLOGIST AND HEARING AID DISPENSER MANUAL
TRANSMITTAL NO. 02-2

ISSUED BY: Bureau of Managed Care and Clinical Services

SUBJECT: ***AUDIOLOGIST AND HEARING AID DISPENSER MANUAL***, Chapter E, *Coverage and Limitations*, pages 15 and 16, revised.

The *Report of Examination for a Hearing Aid*, form 470-0361, is revised to reflect that Section A is to be completed by either an audiologist or a physician. The current version of this form was not finalized before it was printed in the provider manual. Replace it with the updated version, which contains the same revision date as the form currently in the manual.

Date Effective

March 1, 2002

Material Superseded

Remove from the ***Audiologist and Hearing Aid Dispenser Manual*** pages 15 and 16, both dated 10/01, and destroy them.

Additional Information

The updated provider manual containing the revised pages can be found at:

www.dhs.state.ia.us/policyanalysis

If you do not have Internet access, you may request a paper copy of this manual transmittal by sending a written request to:

ACS/Consultec
Manual Transmittal Requests
PO Box 14422
Des Moines, IA 50306-3422

Include your Medicaid provider number, name, address, provider type, and the transmittal number that you are requesting.

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.